DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: 97-26

2. STATE: New York

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
April 1, 1997

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
42 CFR Part 447 Subpart C

7. FEDERAL BUDGET IMPACT:
a. FFY 1996-1997 $-219.3m
b. FFY 1997-1998 $-438.6m

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 4.19-A Part I Pages: Preface, 108, 109, 111, 112, 112(f), 117(a), 117(c), 140, 143, 143(a), 145, 148(b), 177, 179, 180(f), 180(g), 180(i), 226(a)

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Attachment 4.19-A Part 1 Pages: Preface, 108, 109, 111, 112, 112(f), 117(a), 117(c), 140 143, 143(a), 145, 148(b), 177, 179, 180(f), 180(g), 180(i), 226(a)

10. SUBJECT OF AMENDMENT:
Inpatient Hospital Services

11. GOVERNOR'S REVIEW *(Check One)*:

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT ☐ OTHER, AS SPECIFIED:
☒ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL

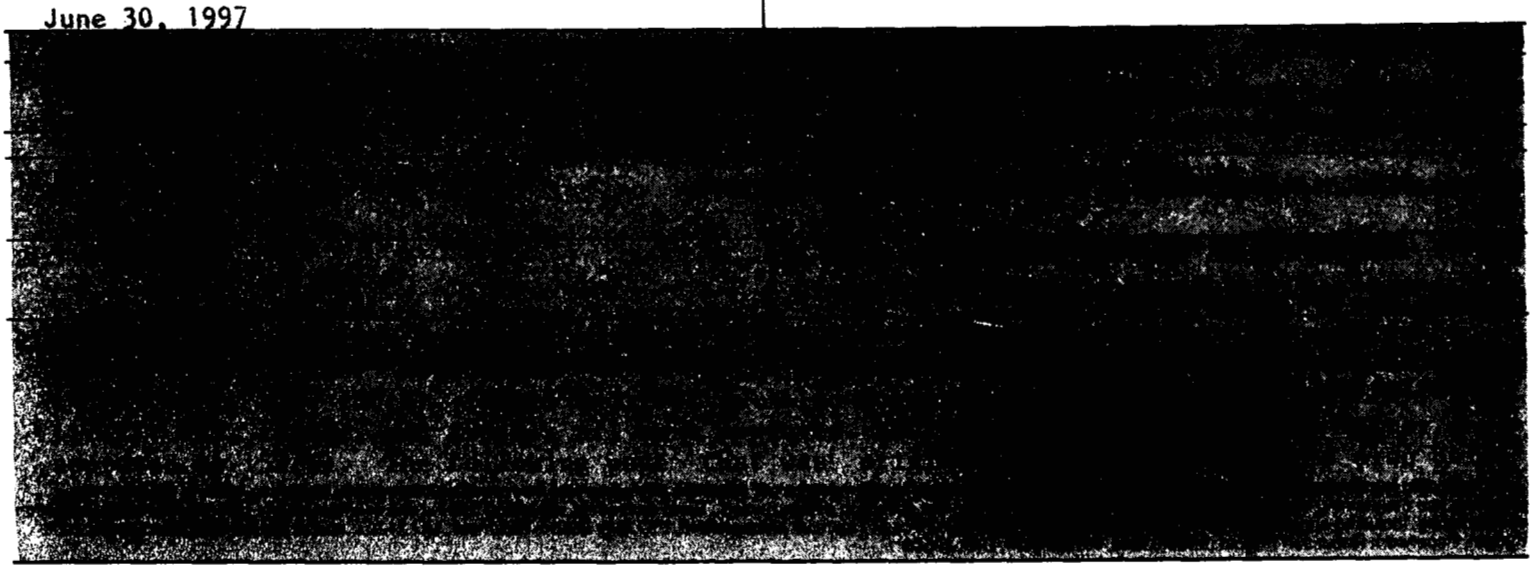
12. SIGNATURE OF STATE AGENCY OFFICIAL:
Barbara A. DeBuono

13. TYPED NAME:
Barbara A. DeBuono, M.D., M.P.H.

14. TITLE:
Commissioner

15. DATE SUBMITTED:
June 30, 1997

16. RETURN TO:
New York State Department of Health
Corning Tower
Empire State Plaza
Albany, New York 12237



FORM HCFA-179 (07-92)

Instructions on Back

(d) For rates of payment for discharges in 1991 and thereafter, a general hospital having less than 201 certified acute non-exempt inpatient beds that is classified as a rural hospital for purposes of determining payment for inpatient services provided to beneficiaries of Title XVIII of the federal Social Security Act (Medicare) since the hospital is located in a rural area as defined by federal law (see 42 U.S.C. section 1395 ww (d)(2)(D)) or defined as a rural hospital under state law may choose to have its DRG specific operating cost component be 100 percent of the hospital's hospital-specific average reimbursable inpatient operating cost per discharge determined pursuant to section 86-1.54 (a) of this Subpart multiplied by the service intensity weight for each DRG set forth in section 86-1.62 of this Subpart, provided however, commencing April 1, 1996 through July 31, 1996 the reimbursable inpatient operating cost component of case based rates of payment per diagnosis-related group excluding the costs of graduate medical education as determined pursuant to sections 86-1.54(g), 86-1.54(h)(1)(iii) and 86-1.54(h)(2), shall be reduced by five percent, and commencing August 1, 1996 through March 31, 1997 the reimbursable impatient operating cost component of case based rates of payment per diagnosis-related group, excluding the costs of graduate medical education as determined pursuant to sections 86-1.54(g), 86-1.54(h)(1)(iii) and 86-1.54(h)(2), shall be reduced by two and five-tenths percent, and commencing April 1, 1997 through March 31, 1999, the reimbursable inpatient operating cost component of case based rates of payment per diagnosis-related group, excluding the costs of graduate medical education as determined pursuant to sections 86-1.54(g), 86-1.54(h)(1)(iii) and 86-1.54 (h)(2), shall be reduced by three and thirty-three hundredths percent to encourage improved productivity and efficiency. In order to exercise this option for 1991 or subsequent rate years, the general hospital shall notify the Department of such election in writing by no later than December first of the preceding rate year or a later date as determined by the Commissioner.

(e) As for discharges on or after April 1, 1995 through March 31, 1999, the DRG case-based rates of payment for patients assigned to one of the twenty most common diagnosis-related groups, will be held to the lower of the facility specific amount or the average amount, as determined pursuant to subdivision (c) of this section for all hospitals assigned to the same peer group. The twenty most common diagnosis-related groups shall be determined using discharge data two years prior to the rate year, but excluding beneficiaries of title XVIII (Medicare) of the federal social security act and patients assigned to diagnosis-related groups for human immunodeficiency virus (HIV) infection, acquired immune deficiency syndrome, alcohol/drug use or alcohol/drug induced organic mental disorders, and exempt unit of exempt hospital patients.

(f) Effective July 1, 1995 through June 30, 1996, rates of payment for inpatient acute care services shall be reduced by the Commissioner to reflect the elimination of operational requirements previously mandated by law, regulation promulgated in accordance with applicable standards and procedures for promulgating hospital operating standards, the Commissioner, or other governmental agency as follows:

(i) An aggregate reduction shall be calculated for each hospital based upon: the result of eighty-nine million dollars annually for 1995 and trended to the rate year, multiplied by a ratio based upon data two years prior to the rate year, consisting of hospital-specific case-based

(i) For discharges on or after April 1, 1997 through March 31, 1999, the DRG case-based rates of payment shall be the sum of:

(1) an amount, determined pursuant to subdivision (c) of this section, excluding those costs for direct and indirect medical education as determined pursuant to sections 86-1.54(g), 86-1.54(h)(1)(iii) and 86-1.54(h)(2) respectively, of this subpart;

(2) minus three and thirty-three hundredths percent of the amount determined in accordance with paragraph (1) of this subdivision to encourage improved productivity and efficiency;

(3) plus the value of direct medical education as determined pursuant to section 86-1.54(g) of this Subpart;

(4) minus three and thirty-three hundredths percent of the costs of hospital based physicians reflected in the direct medical education amount determined pursuant to section 86-1.54(g) of this subpart;

(5) plus the value of forty-five percent of the indirect medical education expenses as determined pursuant to section 86-1.54(h)(1)(iv)-(v) of this subpart;

(6) plus the value of fifty-five percent of the indirect medical education expenses reflected in the hospital's peer group average inpatient operating cost per discharge determined pursuant to section 86-1.54(b) of this Subpart;

(j) Effective July 1, 1996 through March 31, [1997] 1999, rates of payment for inpatient acute care services shall be reduced by the Commissioner to encourage improved productivity and efficiency by a factor determined as follows:

(1) An aggregate reduction shall be calculated for each hospital based on: the result of eighty-nine million dollars and trended to the rate year on an annualized basis for each year, multiplied by the ratio of hospital-specific case based Medicaid patient days, in a base year two years prior to the rate year, consisting of hospital-specific case-based Medicaid patient days divided by the total of such patient days summed for all hospitals.

(2) The result of each hospital shall be allocated to exempt units within such hospital based on the ratio of hospital specific exempt unit Medicaid patient days to hospital specific total Medicaid patient days of which the result is divided by the hospital specific exempt unit Medicaid patient days to produce a unit of service reduction in the per diem rates of payment.

(3) Any amount not allocated to exempt units shall be divided by case based discharges (or for exempt hospitals by patient days) in the base year two years prior to the rate year, resulting in a per case (or for exempt hospitals a per diem) unit of service reduction in payment rates.

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comparable exempt units) volume and case mix adjusted to 1985 using total exempt unit reimbursable costs and cases and trended to 1985 pursuant to section 86-1.15 of this Subpart. The 1985 Medicare share of these costs shall be removed using the percentage used to identify Medicare costs pursuant to section 86-1.54(c) of this Subpart in the event that actual data for the exempt unit or hospital is not available. The non-Medicare exempt unit operating rate shall be further adjusted for changes in volume and case mix from 1985 to 1987 using total reimbursable non-Medicare costs and days and shall be trended to 1987 pursuant to section 86-1.15 of this Subpart. Finally, the 1987 case mix and volume adjusted non-Medicare exempt unit per diem shall be trended to the rate year pursuant to section 86-1.58 of this Subpart and adjusted for changes in case mix and volume in the rate year pursuant to section 86-1.64 of this Subpart on the basis of total non-Medicare reimbursable costs and days for the respective exempt unit and adjusted to include the exempt unit's share of adjustments made pursuant to section 86-1.52(a)(1)(iii)(a), (iv) and (v) of this Subpart.

(i) For rate periods commencing April, 1 1997, rates of payment, excluding any operating cost components related to direct or indirect costs of graduate medical education, for exempt physical medicine rehabilitation, exempt alcohol rehabilitation, exempt drug rehabilitation, exempt epilepsy and exempt psychiatric units of general hospitals, excluding exempt hospitals, shall be held to the lower of the regional average of trended reimbursable inpatient operating cost component of such units established without any limitation imposed excluding the costs of direct medical education or actual costs excluding the costs of direct medical education.

(ii) The reimbursable inpatient operating cost component calculated in subparagraph (i) of this paragraph, excluding any operating cost components related to direct or indirect costs of graduate medical education, shall be reduced by 5% to encourage improved productivity and efficiency.

(2) a capital per diem cost component computed on the basis of budgeted capital costs allocated to the exempt hospital or unit, pursuant to the provisions of section 86-1.59 of this Subpart (or in the case of hospitals and units for which separately identifiable cost and statistical data is not available, a statewide average capital cost per day for comparable exempt units) divided by exempt hospital or unit patient days reconciled to actual total expense; and

(3) a health care services allowance of .614 percent for rate year 1994 and .637 percent for rate year 1995 of the hospital's non-Medicare reimbursable inpatient costs computed without consideration of inpatient uncollectible amounts and after application of this trend factor described in section 86-1.58.

86-1.58 Trend Factor. (a) The commissioner shall establish trend factors for hospitals to project the effects of price movements on historical operating costs. Rates of payment excluding capital, as calculated pursuant to the provisions of section 86-1.52 of this Subpart, shall be trended to the applicable rate year by the trend factors developed in accordance with the provision of this section.

(b) The methodology for establishing the trend factors shall be developed by a panel of four independent consultants with expertise in health economics or reimbursement methodologies for health-related services appointed by the commissioner.

(c) The methodology shall include the appropriate external price indicators and the data from major collective bargaining agreements as reported quarterly by the Federal Department of Labor, Bureau of Labor Statistics, for non-supervisory employees. For 1996 through December 31, 1999, the commissioner shall apply the 1995 trend factor methodology.

(d) The commissioner shall implement one interim adjustment to the trend factors, based on recommendations of the panel, and one final adjustment to the trend factors [based on recommendations of the panel]. Such adjustment shall reflect the price movement in the labor and non labor components of the trend factor. At the same time adjustments are made to the trend factors in accordance with this subdivision, adjustments shall be made to all inpatient rates of payment affected by the adjusted trend factor.

(e) Trend factors used to project reimbursable operating costs to the rate period April 1, 1995 to December 31, 1995 shall not be applied in the development of the rates of payment. This section shall not apply to trend factors, adjusted trend factors of final trend factors used for the January 1, 1995 to December 31, 1995 rate period for purposes of projecting allowable operating costs to subsequent rate periods.

(f) For rate periods commencing April 1, 1996 [and thereafter] <u>through March 31, 1999</u>, shall not reflect trend factor projections or adjustments for the period April 1, 1996 through March 31, 1997 in the development of the rates of payment. This section shall not apply to trend factors or final trend factors used for the January 1, 1995 to December 31, 1995 or January 1, 1996 to March 31, 1996 rate period for purposes of projecting allowable operating costs to subsequent rate periods.

and actual rate year non-exempt unit or hospital-approved capital expense.

(3) Capital payments for transferred and short stay patients shall be the non-exempt hospital's average budgeted capital cost per day determined pursuant to paragraphs (2) and (3) of subdivision (e) of this section.

(g) Effective April 1, 1995 through March 31, 1999, the capital related inpatient expense component of the rate shall be based on the budgeted capital related inpatient expense applicable to the rate year decreased to reflect the percentage amount by which the budget for the applicable base year's capital related expense exceeded actual expense.

(h) Effective April 1, 1995 through March 31, 1999, rates of payment for inpatient acute care services associated with the capital related inpatient expense component and the capital cost per visit components shall be adjusted to exclude such expenses related to the following:

(i) 44% of major moveable equipment
(ii) staff housing.

and actual rate year non-exempt unit or hospital-approved capital expense.

(3) Capital payments for transferred and short stay patients shall be the non-exempt hospital's average budgeted capital cost per day determined pursuant to paragraphs (2) and (3) of subdivision (e) of this section.

(g) Effective April 1, 1995 through March 31, 1999, the capital related inpatient expense component of the rate shall be based on the budgeted capital related expense applicable to the rate year decreased to reflect the percentage amount by which the budget for the applicable base year's capital related inpatient expense exceeded actual expense.

(h) Effective April 1, 1995 through March 31, 1999, rates of payment for inpatient acute care services associated with the capital related expense component and the capital cost per visit components shall be adjusted to exclude such expenses related to the following:

(i) 44% of major moveable equipment

(ii) staff housing.

(l) Adjustments to rates made pursuant to this section shall be made prospectively, and for rate periods commencing January 1, 1997 through March 31, 1999 [and thereafter], may be made prospectively or retrospectively, based on the methodology for calculation of rates of payment for such prospective rate period.

(m) Hospitals may appeal the determination of allowable cumulative increases in case mix for the rate year pursuant to section 86-1.60 of this Subpart based on such factors as changes in hospital service delivery and referral patterns. An appeal pursuant to this section must be submitted within 90 days of receipt of notice of such determination and any modified rate certified pursuant to this subdivision shall be effective as of the date of the case mix adjustment.

(n) The appeal process shall be in accordance with section 86-1.17(c), (e) and (f) of this Subpart, provided, however, that documentation sufficient to support such appeal, including verifiable costs and statistics, must accompany every appeal. Letters of intent to appeal or appeal packages lacking such documentation shall not be accepted or considered to be an appeal.

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(iii) A bad debt and charity care allowance, a health care services allowance and a financially distressed allowance as determined pursuant to the provisions of section 86-1.65 of this Subpart.

(d) Rates of Payment for Acute Care Children's Hospitals. Hospital services provided to non-Medicare patients in acute care children's hospitals shall be reimbursed on a diagnosis-related group basis composed of:

(1) 1994 reimbursable operating costs computed on the basis of the hospital's reimbursable operating costs as defined in paragraph (a)(4) of this section and statistical data for the same period. The base year Medicare share of these costs will be removed in accordance with paragraph (a)(5) of this section. The non-Medicare hospital operating costs shall be trended to the rate year pursuant to section 86-1.58 of this Subpart and further adjusted for changes in volume and case mix from the base to the rate year using total reimbursable non-Medicare costs and statistics of the hospital pursuant to section 86-1.64 of this Subpart. The DRG specific operating cost component shall be computed utilizing one-hundred percent hospital specific reimbursable costs with no adjustment for long stay or high cost outliers pursuant to section 86-1.54(f)(1) and (3) of this Subpart.

(2) The acute cost component computed on the basis of budgeted capital costs allocated to the inpatient portion of the hospital pursuant to the provisions of section 86-1.59 of this Subpart, divided by the budgeted discharges and shall be reconciled to total actual expenses and discharges;

(4) A health care services allowance of .614 percent for rate year 1994 and .637 percent for rate year 1995 of the hospitals' non-Medicare reimbursement inpatient costs computed without consideration of inpatient uncollectible amounts and after application of the trend factor described in section 86-1.58.

(5) Discrete long stay and high cost outlier rates of payment shall not be paid.

(6) For rates of payment for the period April 1, 1996 through July 31, 1996, the operating cost component of rates of payment, excluding any operating cost components related to direct and indirect expenses of graduate medical education for Acute Care Children's Hospitals as determined pursuant to this paragraph shall be reduced by 5%, for the period August 1, 1996 through March 31, 1997 shall be reduced by 2.5% and for the period April 1, 1997 through March 31, 1999, the operating cost component of rates of payment, excluding any operating cost components related to direct and indirect expenses of graduate medical education, shall be reduced by 3.33% to encourage improved productivity and efficiency.